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A scoping review: understanding global integration of traditional, complementary and alternative therapies (TCAT) in end-of-life care (EoLC)

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ABSTRACT

Integration of traditional, complementary and alternative therapies (TCAT) in end-of-life care (EoLC) comprises a complex intersection that challenges conventional implementation frameworks. This scoping review, conducted following Joanna Briggs Institute (JBI) methodology and Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) reporting guidelines, examined how healthcare systems globally integrate and implement TCAT in EoLC for adults. Four electronic databases were searched alongside grey literature sources. Twenty-eight sources met the inclusion criteria, spanning multiple regions and healthcare contexts. Integration models identified included hub and spoke, bedside-to-bench, and unified departmental approaches. Implementation success was influenced by professional collaboration, physical infrastructure, and organisational support systems. The predominant facilitator was organisational support (64.3%), while key barriers included the dominance of Western biomedical paradigms (32.1%), cultural protocol requirements, and resource constraints. Integration patterns varied across therapy types and geographic contexts, with physical therapies demonstrating more structured implementation pathways and traditional healing practices requiring flexible approaches to accommodate cultural requirements. The findings suggest that successful TCAT integration may require flexible yet systematic implementation approaches capable of accommodating cultural variation while maintaining therapeutic integrity. Significant literature gaps exist in formal implementation frameworks, particularly regarding cultural integration protocols and interprofessional collaboration strategies.

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Complementary therapies; end-of-life care; healthcare integration; implementation; scoping review

Introduction

The integration of traditional, complementary and alternative therapies (TCAT) into end-of-life care (EoLC) represents a complex intersection of healthcare approaches that challenge conventional implementation frameworks. In the UK hospice movement and increasingly in healthcare systems worldwide, TCAT has become recognised as an essential component of holistic end-of-life care delivery (Zeng et al., 2018). This integration has gained momentum with the World Health Organisation (WHO) (2024) traditional medicine strategy, which calls upon Member States to develop practical frameworks supporting TCAT integration into health systems. This builds upon the landmark World Health Assembly Resolution WHA67.19 (2014), which called for palliative care to be integrated as a core component of health systems throughout the life course.

EoLC is an individualised personal experience (Mauck, 2022), characterised by focus on comfort and supporting the individual rather than curing disease. During this phase, the goals of medical care shift to a more comfort-oriented model that prioritises the relief of physical, emotional, and spiritual distress, often through palliative care approaches (Mauck, 2022). This holistic orientation is captured in Saunders'

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foundational concept of ‘total pain’, recognising suffering as simultaneously physical, psychological, social, and spiritual (Clark, 1999). Pain’s multidimensional nature creates affinity between palliative care philosophy and TCAT approaches, which similarly attend to the whole person rather than isolated symptoms, making their integration especially salient in EoLC contexts.

While TCAT integration in EoLC is increasingly recognised, the evidence base regarding implementation approaches remains fragmented (Arentz et al., 2020; Lin et al., 2020). Most implementation frameworks offer partial rather than comprehensive approaches, with limited standardised protocols and inconsistent integration strategies. This fragmentation reflects the challenges of merging multiple different healing traditions within conventional healthcare structures and highlights the need for systematic examination of integration practices (Hui et al., 2020).

A fundamental tension exists between conventional evidence-based practice requirements and traditional healing approaches that operate from different epistemological foundations (Oneschuk et al., 2007). Traditional medicine systems often operate from fundamentally different knowledge bases compared to modern medicine, particularly in their understanding of nature, physiology, and pathology (Bates, 2000). Integrating TCAT into healthcare systems represents a dynamic evolution rather than a fixed entity, with the WHO’s recent refinement of the TCAT definition marking a significant milestone in the broader acceptance of diverse medicine systems into mainstream healthcare (Louhiala, 2017).

Established classification frameworks provide structure for understanding TCAT practices. The National Center for Complementary and Integrative Health (NCCIH) categorises approaches under five main headings: alternative treatment systems (such as naturopathy), mind-body therapies (including yoga), manipulative and body-based therapies (including osteopathy), biologically based therapies (such as nutritional supplements), and energy therapies (such as reiki) (Millstine, 2023). The World Health Organisation’s (2019) Global Report on Traditional and Complementary Medicine similarly acknowledges these categories while emphasising that traditional medicine systems are often deeply embedded within cultural and historical contexts. This review adopts an inclusive approach aligned with Ng et al. (2023) recommendation to place different healing systems alongside one another rather than in hierarchical positions, recognising that rigid categorisation may not capture the lived reality of how these practices are integrated in EoLC settings. Despite their heterogeneity, these diverse practices share common analytical ground: they exist largely outside dominant biomedical frameworks, face similar integration challenges within conventional healthcare systems, and typically embody holistic philosophies that attend to physical, emotional, and spiritual dimensions of care.

Even within EoLC itself, the individualised and personal nature of the experience makes definition and standardisation difficult (Mauck, 2022). As TCAT differs from modern medicine in its individualisation and recognition of the whole person, EoLC similarly emphasises personalised care approaches. This alignment creates unique integration opportunities while presenting implementation challenges within conventional healthcare frameworks. Referring to Sawicki (2021), who noted that modern medicine often sees dying as a failure, it could be argued that TCAT and EoLC operate outside the conventional medical model’s parameters, creating opportunities and challenges for integration within existing healthcare systems.

The positioning of TCAT in EoLC can be examined through Parsons’ Theory of Social Action (1937). While Parsons viewed being sick as an undesirable social role, TCAT approaches offer a different paradigm, providing meaningful frameworks that honour cultural perspectives on illness and death, particularly when traditional healing practices are aligned with the patient’s background. Even when therapies originate from different cultural traditions, they may still offer meaningful alternatives to the dominant biomedical approach in EoLC, providing patients with diverse options that align with their personal values and preferences regarding death and dying.

Integration of TCAT in EoLC manifests differently across various healthcare settings, with distinct patterns emerging in hospital-based, community-based, and hospice-specific environments (Ben-Arye et al., 2021; Campbell & Amin, 2014). Each setting presents opportunities and challenges for integration, influencing implementation delivery of traditional healing practices within the broader healthcare framework (Belletti et al., 2011).

Professional integration represents a critical dimension of TCAT implementation in EoLC, with healthcare systems developing diverse staffing models ranging from dedicated integrative physicians to

collaborative practice frameworks incorporating traditional healers (Ben-Arye et al., 2017; Campbell & Amin, 2014). Such professional integration approaches significantly influence incorporation of traditional healing practices within conventional care delivery systems (Kwon et al., 2021).

The implementation landscape reveals various approaches to integration: hub-and-spoke models in rural settings (Jones, 2007) and unified departmental approaches in urban healthcare systems (Hui et al., 2021). Implementation efforts often encounter tensions between evidence-based practice requirements and traditional approaches (Oneschuk et al., 2007), while resource availability and professional integration models significantly influence integration success across different healthcare settings (Ben-Arye et al., 2021; Kwon et al., 2021).

This review examines how healthcare systems integrate traditional healing practices in EoLC settings, considering various implementation frameworks, cultural contexts, and system-level factors, hence contributing to growing knowledge regarding healthcare system integration of TCAT in EoLC, offering insights that can inform policy development and practical implementation strategies across diverse healthcare contexts.

Methods

Study design

This scoping review followed the Joanna Briggs Institute (JBI) methodology guidelines for scoping reviews (Peters et al., 2020) adhering to the PRISMA Extension for Scoping Reviews (PRISMA-ScR) reporting guidelines (Tricco et al., 2018). It followed Arksey and O'Malley (2005) five-stage framework: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarising, and reporting the results. Each stage is detailed in the subsections below, with the completed PRISMA-ScR checklist provided as [supplementary material](#).

Research questions

'What is known about how healthcare systems globally integrate and implement traditional, complementary and alternative therapies in end-of-life care for adults?'

Sub-questions

- What, if any, are the individual traditional, complementary and alternative therapies that are integrated in EoLC for adults?
- What, if any, are the components, mechanisms, and processes associated with the integration and implementation of traditional, complementary and alternative therapies in EoLC for adults?
- Does integration and implementation vary according to the therapy, and if so, how?
- Does the healthcare setting affect integration and implementation, and if so, how?
- Where, if any, are the gaps in the literature?

Search strategy

A comprehensive search strategy was developed and implemented between November 2024 and January 2025. The Yale MeSH Analyzer (Hocking, 2017) identified appropriate Medical Subject Headings (MeSH) terms and their variants. The core MeSH terms were 'End of Life Care', 'Traditional Medicine', 'Complementary Therapies', and 'Healthcare Systems'.

The final search string combined three concept areas using Boolean operators (AND/OR): (1) TCAT terminology (including traditional, complementary, alternative, and integrative medicine/therapy variants, plus acronyms); (2) EoLC terminology (including palliative care, hospice care, terminal care, and related terms); and (3) healthcare system and implementation terminology. The full search string is provided in the [Supplementary Material](#).

Information sources

Searches were completed on 10 January 2025 across four electronic databases: CINAHL (1989–2024), Medline (1981–2025), PsycINFO (1987–2025), and Web of Science (1985–2024). A comprehensive grey literature search was conducted using a modified search string targeting government health websites, professional organisations, specialised grey literature platforms, and institutional repositories, ensuring cultural perspectives, targeted searches included English-language publications from organisations in Asia, multicultural healthcare departments in Australia and Singapore, and Indian Traditional Medicine Resources. This comprehensive approach yielded 14 relevant documents: 8 books, 3 videos, and 3 institutional reports. No date restrictions were applied to capture the full breadth of literature on TCAT integration in EoLC, given that foundational work in this field spans several decades and integration approaches have evolved over time. The search was limited to English-language publications due to resource constraints; this limitation is acknowledged in the discussion. Full details of grey literature sources searched, search terms used, and screening approach are provided in [Supplementary Material](#).

Selection criteria

The review was structured using the Population, Interest, Context (PICo) framework for qualitative evidence synthesis:

- Population: Policymakers, healthcare professionals, and traditional, complementary and alternative therapists working in EoLC
- Interest: Traditional, complementary and alternative therapies
- Context: Adults receiving EoLC in healthcare systems worldwide

Studies were included if they presented empirical or non-empirical evidence regarding TCAT implementation in EoLC, including qualitative studies, mixed-methods research, case studies, literature reviews, practice guidelines, professional commentaries, and implementation frameworks. English language publications from any country or EoLC setting were eligible.

Studies were excluded if they involved participants under 18 years, adults with learning disabilities, adults in prison, patient experiences of receiving TCAT, or outcome measures of TCAT integration.

Screening and study selection

All identified citations were uploaded into Rayyan (Ouzzani et al., 2016), and duplicates were removed. Titles and abstracts were screened independently by two reviewers (CG and DP) against predefined inclusion and exclusion criteria, with disagreements resolved through discussion. Consistent with JBI scoping review methodology, which emphasises breadth of coverage rather than quality appraisal, formal inter-rater reliability statistics were not calculated (Peters et al., 2020)

The full-text review process led to systematic adaptations of the original inclusion criteria ensuring comprehensive coverage while maintaining methodological rigour, consistent with the iterative approach recommended in scoping review methodology (Levac et al., 2010; Peters et al., 2020). Initially, 19 documents met all pre-defined inclusion criteria. Following full-text review, several documents containing valuable implementation insights despite not strictly meeting all initial criteria were identified, leading to the development of an adapted inclusion decision framework.

A decision framework was created to guide systematic adaptation of inclusion criteria. To ensure rigour in adapted inclusion decisions, a second independent reviewer (DR) applied the decision framework to all nine papers where inclusion criteria were adapted, with disagreements resolved through discussion. This resulted in three categories of adaptation:

First, inclusion was expanded incorporating papers that included patient experiences when coupled with substantial documentation of organisational implementation strategies resulting in inclusion of two additional documents: Moore et al. (2013), offering insights into physical organisation of hospice day care spaces, and Lua (2011), providing detailed context about traditional Malay therapy implementation within Malaysian hospices.

Second, five documents examining TCAT integration models outside standard EoLC settings were included based on their significant implementation insights directly transferable to EoLC: Kordi-Tamandani and Hakimifar (2024) documented traditional music therapy implementation mechanisms including practitioner credentialing and ceremonial protocols; Ben-Arye (2015) detailed collaborative care planning processes and infrastructure requirements; Ben-Arye et al. (2017) provided a comprehensive 'bedside-to-bench' implementation model; Ben-Arye et al. (2021) presented structured implementation approaches for pain management in advanced illness; and Adams (2004) documented professional boundary-work and occupational integration mechanisms.

Third, two implementation-focused documents were included for their significant contributions to healthcare system implementation processes in EoLC despite not specifically referencing TCAT: Hui et al. (2020) provided frameworks for measuring palliative care integration levels, and Radbruch et al. (2020) offered consensus-based definitional work shaping system-level integration of palliative services.

The decision framework limited inclusion to documents offering direct insights into integration mechanisms specific to therapeutic approaches similar to TCAT, prioritised implementation documents addressing healthcare contexts with comparable characteristics to EoLC settings (e.g. complex symptom management, multidisciplinary care, cultural sensitivity requirements), and included only non-EoLC documents providing substantial and unique implementation insights not already captured in EoLC-specific literature. This selective approach prevented data saturation with repetitive implementation concepts while ensuring the review remained manageable in scope and directly relevant. These adaptations aligned with Arksey and O'Malley (2005) recommendation that scoping reviews maintain flexibility, accommodating emerging insights during the review process. All adaptations were documented ensuring transparency and methodological rigour.

9 of the 28 included sources (32%) were incorporated through adapted criteria, with 19 sources meeting all original pre-defined criteria. The decision framework guiding these adaptations is provided in the [Supplementary Material](#). While this adaptive approach enhanced the comprehensiveness of implementation insights captured, it may limit direct transferability of findings to contexts where stricter inclusion boundaries are applied. However, this flexibility is consistent with scoping review methodology, which prioritises breadth of coverage over restrictive eligibility criteria (Levac et al., 2010).

Data extraction

A comprehensive data extraction framework was developed in Microsoft Excel to systematically extract and organise relevant information from the included studies. A single author (CG) extracted study data. The framework encompassed seven key domains: (1) Study Characteristics, (2) Population Characteristics, (3) Implementation Components, (4) Healthcare System Context, (5) EoLC Specific Elements, (6) Outcomes and Evaluation, and (7) Data Analysis.

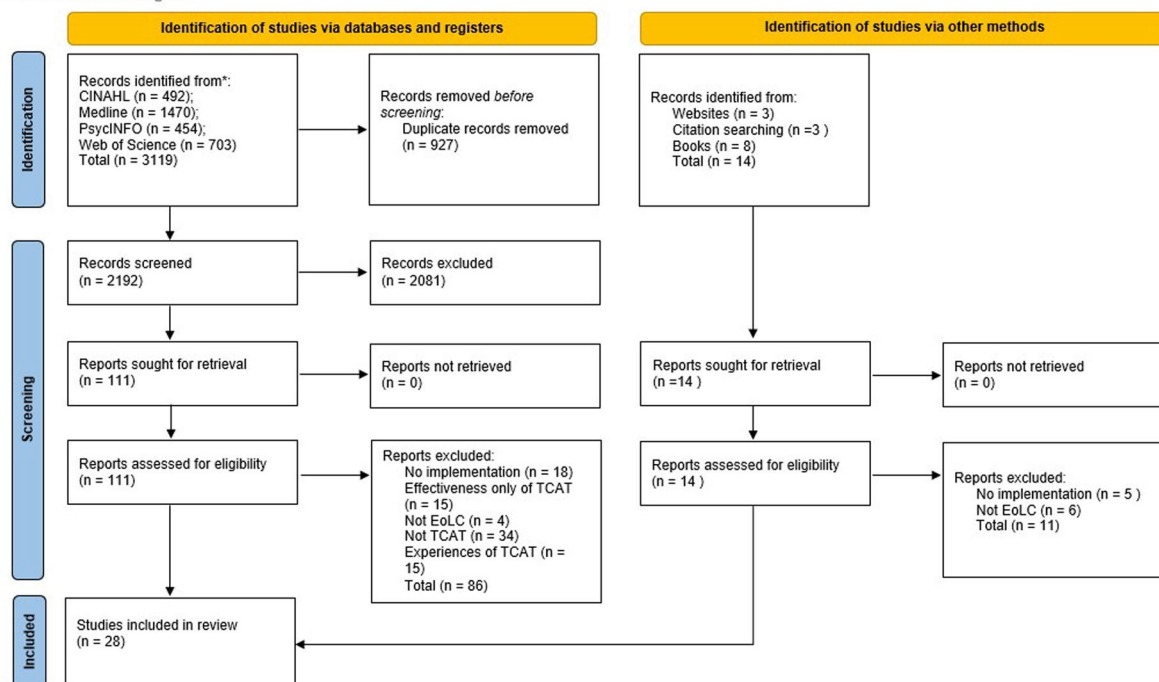
Data synthesis

The extracted data was synthesised using a narrative descriptive approach following five key stages (Arksey & O'Malley, 2005): initial familiarisation with the extracted data, identification of recurring patterns and themes, grouping of similar findings and approaches, analysis of variations and contradictions in implementation approaches, and synthesis of key findings related to each research question. A reflexive approach was maintained throughout, with regular review of emerging themes ensuring consistency in interpretation and to minimise potential bias. Consistent with scoping review methodology, aiming to map the breadth of available evidence rather than synthesise quality-appraised findings (Peters et al., 2020), formal critical appraisal was not conducted and single-author data extraction was employed. The implications for interpretation are addressed in the limitations.

Results

The electronic database search identified 3,119 records from four databases: CINAHL (n=492), Medline (n=1,470), PsycINFO (n=454), and Web of Science (n=703). An additional 14 records were identified

PRISMA 2020 flow diagram



Source: Page MJ, et al. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71.

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Figure 1. PRISMA-ScR flow diagram of the study selection process (adapted from Page et al., 2021).

through other sources. After removing 927 duplicates, 2,192 records were screened, with 2,081 excluded based on title and abstract. Following full-text assessment using the adaptive selection approach, 28 studies were included (Figure 1).

Characteristics of included studies

The 28 included studies spanned three decades (1994–2024), representing diverse methodological approaches: 12 qualitative studies, 4 mixed-methods, 5 case studies, 5 literature reviews, 1 commentary and 1 practice guidelines. Geographically, contributions came from America and Canada (6), Europe (14), Asia (4), and 4 global studies. Settings included hospital-based (7), hospice facilities (9), and specialist community care (1), with 11 examining multiple settings. Most studies (17) were conducted in government-funded healthcare systems, 8 in mixed public-private systems, and 3 in privately-funded settings.

Classification of TCAT varied considerably. Belletti et al. (2011) employed the National Center for Complementary and Alternative Medicine (NCCAM) framework, categorising interventions into mind-body medicine, biologically-based therapies, manipulative and body-based therapies, energy therapies, and whole medical systems. Cultural context influenced terminology: Lua (2011) classified interventions as Complementary Indigenous Malay Therapies (CIMT), recognising them as cultural heritage; Rooney et al. (2022) used ‘traditional therapies’ in Australian Aboriginal contexts; while Ben-Arye et al. (2021) employed ‘Integrative Oncology’ (IO), defined as a ‘patient-centered, evidence-informed field’ (pp. 2362). Healthcare contexts shaped specific classifications, with Jones (2007) using ‘complementary and psychological therapies’, Jaman-Mewes et al. (2024) focusing on ‘spiritual care interventions’, and Rosa et al. (2019) using ‘sacred medicine’.

While these studies represent the most comprehensive available evidence, most offered partial rather than complete implementation frameworks, typically providing insights into specific elements such as integration mechanisms or organisational processes rather than standardised, system-wide approaches.

In summary, the 28 included sources represent diverse methodological approaches, geographic contexts, and TCAT classification systems, though most offered partial rather than comprehensive implementation frameworks.

Individual TCAT integrated in EoLC

The most commonly reported interventions included massage therapy, music therapy, and aromatherapy. Kwon et al. (2021) survey of South Korean hospice facilities found music therapy in 79.7% of facilities and aromatherapy in 57.6%. Mind-body interventions featured prominently, with Jaman-Mewes et al. (2024) documenting mindfulness meditation, guided imagery, and relaxation techniques across multiple settings. Energy-based therapies including Reiki and therapeutic touch were documented widely (Adams, 2004; Arentz et al., 2020; Ben-Arye, 2015; Ben-Arye et al., 2017; Buckley, 2008; Halpin, 2006; Lua, 2011; Oneschuk et al., 2007).

Traditional medicine systems were well-represented: Lin et al. (2020) detailed Traditional Chinese Medicine integration across eight Taiwanese hospice wards; Rooney et al. (2022) documented Aboriginal healing practices including bush medicines; Campbell and Amin (2014) described traditional healers' (Sangomas and Inyangas) roles in rural South Africa; and Gaikwad and Acharya (2022) detailed Ayurveda, Siddha, and Unani integration in India. Creative arts-based interventions, particularly art therapy, were frequently reported (Ben-Arye et al., 2017; Moore et al., 2013). Multi-modal approaches were common, as documented in Ben-Arye et al. (2021) integration of acupuncture, manual therapies, and mind-body-spirit interventions within oncology services.

In summary, massage therapy, music therapy, and aromatherapy were most commonly reported, with multi-modal approaches prevalent across settings and traditional medicine systems varying significantly by cultural context.

Components, mechanisms, and processes of TCAT integration

Core components

Successful integration required three fundamental elements. Professional staffing emerged as critical, particularly integrative physicians with dual training who bridge therapeutic paradigms (Ben-Arye et al., 2017; Kwon et al., 2021; Wright, 2004). Physical infrastructure requirements included dedicated therapy spaces and culturally appropriate areas, as exemplified in Canadian healthcare settings with dedicated family rooms for cultural practices (Kaufert et al., 1999), UK hospice environments designed as non-clinical spaces (Moore et al., 2013), and strategic rural venues (Jones, 2007). Organisational systems encompassing referral pathways, documentation, and evaluation protocols were essential, with both Ben-Arye et al. (2021) and Bourke et al. (2016) highlighting integrated documentation systems accessible to both conventional and complementary providers.

Integration mechanisms

At clinical level, integration began with consultations, integrative physicians developing co-designed treatment programmes with patients, exemplified in Israeli model's hour-long consultations exploring patient narratives (Ben-Arye et al., 2017). Communication mechanisms, specifically weekly staff meetings between practitioners, facilitated knowledge-sharing and collaborative decision-making (Kwon et al., 2021). Cultural mediation emerged as another mechanism, Australian and Canadian models demonstrating how interpreters and mediators bridge different paradigms, including accommodating ceremonies such as sweetgrass burning within hospital settings (Campbell & Amin, 2014; Kaufert et al., 1999).

Integration models

Three distinct models emerged. Jones's (2007) study described a hub and spoke model, the main hospital serving as the 'hub' coordinating services, 'spokes' being strategic venues county-wide, overcoming geographical barriers through partnerships with voluntary organisations. The 'bedside-to-bench' model (Ben-Arye

et al., 2017) operates as a cyclical knowledge translation system, beginning with patient care observations, developing research questions, and translating findings back into clinical guidelines through multidisciplinary teams across seven Israeli oncology centres. Hui et al. (2021) unified departmental model consolidates all supportive care services under single administrative structure, featuring universal referral systems, systematic screening, tailored specialist involvement, and streamlined care delivery through consolidated appointments.

Integration patterns

Integration occurred at multiple points, with 82.1% (n=23) of studies reporting multiple integration points throughout the EoLC journey. Continuous integration throughout the entire palliative care trajectory appeared in 32.1% (n=9), with Ben-Arye et al. (2021) documenting integration throughout the cancer care continuum. Patient preference and clinical need determined timing in 64.3% (n=18) of studies.

Professional integration was central, with 64.3% (n=18) describing collaborative practice models including team-based delivery (Kwon et al., 2021), hierarchical supervision models (Oneschuk et al., 2007), and coordinated care with formal referral pathways (Lin et al., 2020). Traditional healers' integration with conventional teams was documented in 32.1% (n=9), including South African Sangomas (Campbell & Amin, 2014) and Aboriginal healers conducting ceremonies within hospital settings (Kaufert et al., 1999).

Cultural integration

Cultural integration was key, 46.4% (n=13) documenting incorporation of traditional healing methods native to local contexts (Lua, 2011; Rooney et al., 2022). Kordi-Tamandani and Hakimifar (2024) documented how Gowâti music therapy in Iran maintained cultural authenticity through strict ceremonial protocols, traditional knowledge transmission pathways, and practitioner qualifications based on hereditary lineage. Cultural rituals featured in 39.3% (n=11), with 35.7% (n=10) highlighting cultural competency training's importance.

In summary, successful integration appeared to require three core components (professional staffing, physical infrastructure, and organisational systems), with three distinct models identified: hub and spoke, bedside-to-bench, and unified departmental approaches.

Implementation barriers and facilitators

Barriers

The dominance of Western medicine (32.1%, n=9) created tensions with traditional approaches. Western medicine's emphasis on curative treatment sometimes conflicted with holistic approaches accepting death as natural (Kwon et al., 2021; MacCormack, 1994). Healthcare providers exhibited scepticism towards traditional therapies, with Lin et al. (2020) finding 89.7% of Taiwanese professionals reported absence of suitable clinical practice guidelines. This created reluctance among First Nations peoples to discuss traditional medicine use for fear of dismissal (Rooney et al., 2022). Institutional barriers included communication issues, policies misaligned with traditional approaches (Rooney et al., 2022), lack of formal integration frameworks (Lua, 2011), and regulatory issues around practitioner accreditation (Oneschuk et al., 2007).

Over 40% of literature revealed challenges concerning sacred traditions, including hereditary knowledge transmission requirements where healing abilities must pass through family lineages (Kordi-Tamandani & Hakimifar, 2024), and tensions between preserving ceremonial requirements and meeting healthcare regulations (Campbell & Amin, 2014; Rooney et al., 2022).

Resource constraints (n=11) included financial barriers as the most reported constraint (Arentz et al., 2020), with 67% of Canadian providers identifying funding limitations (Oneschuk et al., 2007) and Wright (2004) noting most US hospice complementary therapies were paid out-of-pocket. Physical resource and staffing constraints were documented across systems, with 90.8% of Taiwanese professionals reporting insufficient knowledge (Lin et al., 2020). Geographic barriers were particularly evident in rural Aboriginal communities (Rooney et al., 2022) and across Indian regional disparities (Gaikwad & Acharya, 2022).

Facilitators

Organisational support was the predominant enabler (64.3%, n=18), including insurance coverage, qualification requirements (96.3% holding certifications in Kwon et al., 2021), formal complementary and alternative medicine (CAM) committees (Wright, 2004), and leadership support (Jones, 2007; Belletti et al., 2011). Cultural and community factors (42.9%, n=12) included Aboriginal health worker support and community engagement (Rooney et al., 2022), cultural mediator roles (Kaufert et al., 1999), community acceptance (Campbell & Amin, 2014), and hospice philosophy's alignment with holistic approaches (MacCormack, 1994). Professional development (n=10) encompassed therapist qualifications (Kwon et al., 2021), previous TCAT training (Lin et al., 2020), and educational partnerships (Arentz et al., 2020). Team collaboration (n=7) through regular meetings (Bourke et al., 2016), non-hierarchical teams (MacCormack, 1994), and cross-professional arrangements (Jones, 2007) also facilitated integration.

In summary, organisational support was the predominant facilitator (64.3%), while key barriers included Western medicine dominance (32.1%), sacred tradition requirements, and resource constraints.

Variation across therapy types

Physical therapies demonstrated the most structured integration patterns, with 96.3% of South Korean practitioners holding formal qualifications from professional associations (58.1%), academic societies (15.2%), and universities (12.3%) (Kwon et al., 2021). Similarly structured integration was documented in Italian hospices (Belletti et al., 2011) and UK rural settings (Halpin, 2006; Jones, 2007). Creative therapies showed high adoption: horticultural therapy (81.4%), music therapy (79.7%), and art therapy (76.3%) in South Korean facilities (Kwon et al., 2021), with implementation documented across multiple countries (Jaman-Mewes et al., 2024; Moore et al., 2013). Mind-body interventions demonstrated flexible implementation with adaptable delivery formats across hospices, hospitals, and home environments (Jaman-Mewes et al., 2024; Rosa et al., 2019; Wright, 2004). Traditional medicine systems varied significantly by cultural context, from Indigenous healing practices requiring cultural sensitivity (Rooney et al., 2022), to Taiwan's formalised Traditional Complementary Medicine (TCM) integration (Lin et al., 2020), and informal patient-directed approaches in Malaysia (Lua, 2011).

Healthcare settings and their impact

Four settings were identified: hospital-based (35.7%, n=10), community-based (28.6%, n=8), hospice-specific (n=6), and mixed/integrated (n=4). Healthcare delivery models comprised integrated care (42.9%, n=12), traditional/cultural (n=6), facility-based (n=5), and community-based (n=5).

Hospital-based integration demonstrated structured implementation, with Ben-Arye et al. (2021) documenting a three-tier structure in Israeli oncology (89% of patients receiving complementary treatments during chemotherapy), Lin et al. (2020) detailing systematic integration across eight Taiwanese wards, and Hui et al. (2020) finding National Cancer Institute (NCI)-designated centres showing higher integration scores (median 6.1) than non-designated centres (median 4.5). Within hospice settings, Belletti et al. (2011) reported 80% employed massage therapy, 93% maintained formal evaluation protocols, and 86.7% conducted weekly team discussions. Community-based settings showed flexibility and cultural adaptation, traditional healers working alongside conventional providers (Campbell & Amin, 2014). Kaufert et al. (1999) documented dedicated cultural spaces and cultural mediators bridging hospital protocols with traditional practices.

In summary, hospital-based settings demonstrated more structured implementation, while community-based settings showed greater flexibility and cultural adaptation.

Literature gaps

Significant gaps emerged in implementation frameworks, with Lin et al. (2020) reporting 89.6% noted absence of suitable clinical practice guidelines. Cultural integration lacked well-defined frameworks and collaboration structures (Campbell & Amin, 2014), with spiritual care often viewed through Western-centric perspectives (Hardy & Flemming, 2023). System integration gaps included lack of

unified administrative structures (Hui et al., 2020) and undocumented referral management coordination (Bourke et al., 2016).

Discussion

This scoping review reveals significant insights regarding TCAT integration in EoLC settings globally, highlighting complex intersections between healing paradigms, implementation frameworks, and cultural contexts. The evidence identified primarily comprises qualitative reports and observational studies; reported benefits such as symptom relief and enhanced well-being reflect patient-reported experiences rather than controlled evaluations using validated palliative care outcome measures, hence limiting conclusions regarding therapeutic effectiveness.

Paradigmatic tensions and integration

The included sources reveal a fundamental tension between the biomedical model's reductionist approach and the holistic orientation of many traditional healing systems. This tension, historically rooted in different epistemological approaches (Wear, 1995), echoes Coulter and Willis (2004) observation that TCAT and Western medicine operate in fundamentally different paradigms. The included sources suggest that integration appears more likely to occur when healthcare systems accommodate these differences rather than forcing traditional practices into conventional frameworks. This is evident in Kwon et al. (2021) documentation of South Korean hospice facilities achieving >75% integration rates through formal recognition while maintaining therapeutic integrity, Jones's (2007) establishment of shared referral pathways preserving distinct approaches, Ben-Arye et al. (2017) creation of space for both paradigms across seven oncology centres, Wright's (2004) CAM committee bridging practitioners, and Kaufert et al. (1999) designated spaces preserving Aboriginal ceremonial integrity.

Cultural integration and implementation

The included sources reveal significant variation in cultural integration approaches, supporting Caspi et al. (2003) assertion that individual needs should drive TCAT definition. Successful integration of Indigenous practices required substantial adaptation of conventional frameworks (Campbell & Amin, 2014; Rooney et al., 2022). However, the dominance of Western medicine (identified as a barrier in 32.1% of studies) reflects Bates's (2000) observation that 20th-century paradigms emphasised disease as specific entity rather than considering illness within broader contexts.

Several studies demonstrate successful cultural integration models. Kordi-Tamandani and Hakimifar (2024) preserved traditional Gowâti knowledge transmission while establishing systematic protocols; Ben-Arye et al. (2017) 'patient-tailored integrative oncology model' honoured both individual health beliefs and socio-cultural-religious contexts; and Adams (2004) identified successful 'boundary-work' creating spaces accommodating both paradigms.

Implementation frameworks and system integration

The included sources identified a significant gap in formal implementation frameworks (89.6% of healthcare systems lacking suitable guidelines; Lin et al., 2020). This may reflect broader challenges of standardising approaches while maintaining flexibility for cultural variation (Hoenders et al., 2024). Three distinct integration models emerged with varying success. Jones's (2007) hub and spoke model demonstrated effective rural service delivery through strategic community partnerships. Ben-Arye et al. (2017) bedside-to-bench model showed promising outcomes across seven oncology centres through cyclical knowledge translation. Hui et al. (2021) unified departmental model addressed fragmentation in supportive care delivery, though its implementation remains more conceptual. However, these models primarily emerged from Western contexts, raising questions about cross-cultural applicability (Ng et al., 2023).

Professional integration and resource distribution

Professional integration emerged as crucial (64.3% describing collaborative practice models), though resource constraints and professional hierarchies influence implementation success, reflecting Gaboury et al. (2012) 'moving target' nature of integration. Successful professional integration often depends on organisational support and systematic qualification requirements (96.3% holding certifications in Kwon et al., 2021), though this formalisation may create tensions with traditional practices relying on different knowledge transmission forms.

Therapeutic integration patterns

Notable variation emerged across therapeutic modalities. Physical and manual therapies demonstrated the most structured integration, possibly due to alignment with conventional delivery models and inclusion in national guidelines (e.g. National Institute for Health and Care Excellence (NICE) NG193, 2021 recommending acupuncture for chronic pain). However, this raises questions about whether standardisation compromises holistic principles underlying traditional practices (Hoenders et al., 2024). High adoption rates of creative therapies in South Korean facilities (Kwon et al., 2021) suggest these modalities face fewer barriers, perhaps due to their capacity to address psychological and spiritual aspects while fitting existing frameworks. As Murali (2020) emphasises, end-of-life is a phase where individuals plan through personal decision-making, suggesting the need for flexible approaches accommodating individual preferences.

Cultural competency and healthcare delivery

Cultural mediation mechanisms (Kaufert et al., 1999) demonstrate how healthcare systems can bridge paradigms while maintaining cultural integrity, aligning with Salins et al.'s (2018) emphasis on individualising definitions to meet cultural needs. A significant distinction emerges between integrating indigenous traditional therapies versus adopting therapies from outside cultural contexts. Indigenous practice integration requires navigating complex historical relationships characterised by past suppression (Campbell & Amin, 2014; Rooney et al., 2022), while non-native therapies face different challenges including unfamiliarity and tendency towards oversimplification (Ben-Arye et al., 2017; Lin et al., 2020). Physical infrastructure, including dedicated cultural spaces and family grieving rooms (Kaufert et al., 1999), plays a crucial role in cultural integration.

Time and implementation considerations

The unfixed aspects of integration emerged as significant, with 82.1% of studies reporting multiple integration points, supporting the need for flexible implementation frameworks.

Future directions and implications

This review identifies several areas requiring further development: standardised yet flexible implementation frameworks accommodating different cultural contexts; professional development models bridging conventional and traditional approaches; resource allocation strategies supporting sustainable, equitable integration; and cultural competency frameworks specifically designed for TCAT in EoLC. The findings suggest successful integration requires fundamental shifts in how healthcare systems approach different healing paradigms, potentially representing a transitional phase in healthcare evolution (Kuhn, 1996).

Policy implications include regulatory frameworks recognising traditional credentials while respecting cultural knowledge transmission (Lin et al., 2020; Rooney et al., 2022), moving towards genuinely integrative approaches honouring different epistemological foundations (Ben-Arye et al., 2017). Professional practice implications emphasise cross-cultural competency training (Kwon et al., 2021; Wright, 2004), cultural mediators (Kaufert et al., 1999), and incorporating traditional healers as legitimate providers (Campbell & Amin, 2014; MacCormack, 1994). Healthcare system design implications include flexible

infrastructure accommodating different approaches (Jones, 2007; Moore et al., 2013), structured frameworks (Hui et al., 2021), and cultural flexibility (Kordi-Tamandani & Hakimifar, 2024; Rooney et al., 2022).

Additionally, systematic exploration of ethical dimensions – including informed consent, potential interactions with conventional treatments, practitioner regulation, and managing expectations at end of life – warrants further attention in future research.

Strengths and limitations

This review employed a comprehensive search strategy across multiple databases, grey literature, and diverse cultural contexts, resulting in studies representing varied healthcare systems globally. The systematic data extraction framework allowed consistent analysis across diverse study types. Conceptually, the review identifies concrete implementation models, examines both barriers and facilitators, and includes traditional practices from their cultural contexts rather than solely through a Western lens.

Several limitations should be acknowledged. The review is limited by the methodological quality of included studies, many lacking formal evaluation methods. The predominance of descriptive case studies and qualitative research, while valuable for understanding implementation contexts, limits causal inference; findings reflect implementation descriptions and reported experiences rather than evidence of effectiveness.

Language limitations restricted the review to English-language publications, potentially excluding important insights from non-English contexts – particularly significant given the cultural diversity of traditional practices. The included sources are weighted towards certain regions, particularly the UK, US, and parts of Asia, with comparatively less representation of Indigenous or minority healing practices within high-income Western countries; caution should therefore be exercised when generalising findings across different healthcare infrastructures and cultural contexts. The deliberately broad scope limited depth of analysis for specific models.

Furthermore, while this review groups diverse practices under the umbrella term TCAT for analytical purposes, this should not be interpreted as implying equivalence across culturally distinct traditions or healthcare contexts.

Finally, publication bias may have resulted in overrepresentation of successful integration approaches compared to implementation challenges or failed attempts.

Conclusion

This scoping review offers significant insights into how healthcare systems globally integrate and implement traditional, complementary and alternative therapies in end-of-life care. The findings reveal complex interactions between different healing paradigms, cultural contexts, and implementation frameworks that shape integration efforts across various healthcare settings.

The findings suggest that successful integration of TCAT in EoLC may involve more than simply incorporating traditional practices into conventional healthcare frameworks. Rather, the literature indicates this may benefit from reconsideration of how healthcare systems approach the intersection of different healing traditions. The identified implementation models – hub and spoke, bedside-to-bench, and unified departmental – provide promising frameworks, yet their effectiveness varies significantly across cultural contexts.

The review also reveals distinct geographic patterns in integration approaches. Hospice and palliative care settings in the UK and US demonstrate more established complementary therapy provision, while Middle Eastern contexts show particular strength in traditional herbal medicine integration within oncology services. Studies from South Korea, Taiwan, and Malaysia highlight how cultural healing traditions shape service delivery, whilst research from South Africa, Canada, and Australia emphasises the ongoing challenges of incorporating Indigenous healing practices into Western-dominated healthcare systems. These geographic variations underscore that integration strategies cannot be universally applied but must be adapted to local healthcare infrastructures, cultural contexts, and existing therapeutic traditions.

A key finding from the included sources is the persistent tension between standardisation requirements and the need to maintain cultural integrity and therapeutic authenticity. While some therapies, particularly physical and manual interventions, demonstrate successful structured integration, others, especially traditional healing practices, require more flexible approaches that can accommodate different cultural paradigms and individual preferences.

The review identifies significant gaps in current implementation frameworks, particularly regarding professional collaboration and service organisation. Barriers include persistent scepticism among medical professionals regarding therapeutic efficacy, inconsistent qualification standards and pay structures for therapists, lack of designated treatment spaces within healthcare facilities, and limited access to patient information systems. These organisational challenges are compounded by the absence of systematic approaches to credentialing, training standardisation, and interdisciplinary communication. Addressing these gaps may require attention to both structural factors and the cultural shift needed to position complementary therapists as valued members of palliative care teams.

The synthesis of current knowledge provides a foundation for understanding how healthcare systems can better serve diverse populations through integrated EoLC approaches that honour both traditional healing practices and contemporary healthcare requirements. The findings have significant implications for policy development, professional practice, and healthcare system design, suggesting that successful integration requires a paradigm shift in how healthcare systems approach different healing traditions.

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Data availability statement

This scoping review analysed published literature. All data extracted from included studies are presented in the manuscript. The search strategy and full list of included sources are available from the corresponding author upon reasonable request.

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